

8339

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		/d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MADISON E BROWN SR.</u>		4. DATE OF DEATH Month Day Year <u>JULY 30 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 18 - 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE BROWN</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE WALTERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>LEONARD BROWN</u>		Address <u>CHESTER MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute meningitis</u> <u>600.0</u> DUE TO <u>acute Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostate Hypertrophy several years Parkinson's Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>54 years</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 10</u> , 19 <u>40</u> to <u>July 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>59</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Stevensville Md</u> DATE SIGNED <u>July 31, 1959</u> ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D. <u>Stevensville Md</u> PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER</u> <u>STEVENSVILLE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 1</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2338

<p>1. NAME OF DECEASED                  [Illegible]</p>		<p>2. SEX                  [Illegible]</p>	
<p>3. AGE                  [Illegible]</p>		<p>4. DATE OF BIRTH                  [Illegible]</p>	
<p>5. PLACE OF BIRTH                  [Illegible]</p>		<p>6. OCCUPATION                  [Illegible]</p>	
<p>7. MARITAL STATUS                  [Illegible]</p>		<p>8. CAUSE OF DEATH                  [Illegible]</p>	
<p>9. MEDICAL HISTORY                  [Illegible]</p>		<p>10. DATE OF DEATH                  [Illegible]</p>	
<p>11. PLACE OF DEATH                  [Illegible]</p>		<p>12. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>13. SIGNATURE OF WITNESS                  [Illegible]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Illegible]</p>	
<p>15. SIGNATURE OF CORONER                  [Illegible]</p>		<p>16. SIGNATURE OF JURY                  [Illegible]</p>	
<p>17. SIGNATURE OF JURY                  [Illegible]</p>		<p>18. SIGNATURE OF JURY                  [Illegible]</p>	
<p>19. SIGNATURE OF JURY                  [Illegible]</p>		<p>20. SIGNATURE OF JURY                  [Illegible]</p>	
<p>21. SIGNATURE OF JURY                  [Illegible]</p>		<p>22. SIGNATURE OF JURY                  [Illegible]</p>	
<p>23. SIGNATURE OF JURY                  [Illegible]</p>		<p>24. SIGNATURE OF JURY                  [Illegible]</p>	
<p>25. SIGNATURE OF JURY                  [Illegible]</p>		<p>26. SIGNATURE OF JURY                  [Illegible]</p>	
<p>27. SIGNATURE OF JURY                  [Illegible]</p>		<p>28. SIGNATURE OF JURY                  [Illegible]</p>	
<p>29. SIGNATURE OF JURY                  [Illegible]</p>		<p>30. SIGNATURE OF JURY                  [Illegible]</p>	
<p>31. SIGNATURE OF JURY                  [Illegible]</p>		<p>32. SIGNATURE OF JURY                  [Illegible]</p>	
<p>33. SIGNATURE OF JURY                  [Illegible]</p>		<p>34. SIGNATURE OF JURY                  [Illegible]</p>	
<p>35. SIGNATURE OF JURY                  [Illegible]</p>		<p>36. SIGNATURE OF JURY                  [Illegible]</p>	
<p>37. SIGNATURE OF JURY                  [Illegible]</p>		<p>38. SIGNATURE OF JURY                  [Illegible]</p>	
<p>39. SIGNATURE OF JURY                  [Illegible]</p>		<p>40. SIGNATURE OF JURY                  [Illegible]</p>	
<p>41. SIGNATURE OF JURY                  [Illegible]</p>		<p>42. SIGNATURE OF JURY                  [Illegible]</p>	
<p>43. SIGNATURE OF JURY                  [Illegible]</p>		<p>44. SIGNATURE OF JURY                  [Illegible]</p>	
<p>45. SIGNATURE OF JURY                  [Illegible]</p>		<p>46. SIGNATURE OF JURY                  [Illegible]</p>	
<p>47. SIGNATURE OF JURY                  [Illegible]</p>		<p>48. SIGNATURE OF JURY                  [Illegible]</p>	
<p>49. SIGNATURE OF JURY                  [Illegible]</p>		<p>50. SIGNATURE OF JURY                  [Illegible]</p>	
<p>51. SIGNATURE OF JURY                  [Illegible]</p>		<p>52. SIGNATURE OF JURY                  [Illegible]</p>	
<p>53. SIGNATURE OF JURY                  [Illegible]</p>		<p>54. SIGNATURE OF JURY                  [Illegible]</p>	
<p>55. SIGNATURE OF JURY                  [Illegible]</p>		<p>56. SIGNATURE OF JURY                  [Illegible]</p>	
<p>57. SIGNATURE OF JURY                  [Illegible]</p>		<p>58. SIGNATURE OF JURY                  [Illegible]</p>	
<p>59. SIGNATURE OF JURY                  [Illegible]</p>		<p>60. SIGNATURE OF JURY                  [Illegible]</p>	
<p>61. SIGNATURE OF JURY                  [Illegible]</p>		<p>62. SIGNATURE OF JURY                  [Illegible]</p>	
<p>63. SIGNATURE OF JURY                  [Illegible]</p>		<p>64. SIGNATURE OF JURY                  [Illegible]</p>	
<p>65. SIGNATURE OF JURY                  [Illegible]</p>		<p>66. SIGNATURE OF JURY                  [Illegible]</p>	
<p>67. SIGNATURE OF JURY                  [Illegible]</p>		<p>68. SIGNATURE OF JURY                  [Illegible]</p>	
<p>69. SIGNATURE OF JURY                  [Illegible]</p>		<p>70. SIGNATURE OF JURY                  [Illegible]</p>	
<p>71. SIGNATURE OF JURY                  [Illegible]</p>		<p>72. SIGNATURE OF JURY                  [Illegible]</p>	
<p>73. SIGNATURE OF JURY                  [Illegible]</p>		<p>74. SIGNATURE OF JURY                  [Illegible]</p>	
<p>75. SIGNATURE OF JURY                  [Illegible]</p>		<p>76. SIGNATURE OF JURY                  [Illegible]</p>	
<p>77. SIGNATURE OF JURY                  [Illegible]</p>		<p>78. SIGNATURE OF JURY                  [Illegible]</p>	
<p>79. SIGNATURE OF JURY                  [Illegible]</p>		<p>80. SIGNATURE OF JURY                  [Illegible]</p>	
<p>81. SIGNATURE OF JURY                  [Illegible]</p>		<p>82. SIGNATURE OF JURY                  [Illegible]</p>	
<p>83. SIGNATURE OF JURY                  [Illegible]</p>		<p>84. SIGNATURE OF JURY                  [Illegible]</p>	
<p>85. SIGNATURE OF JURY                  [Illegible]</p>		<p>86. SIGNATURE OF JURY                  [Illegible]</p>	
<p>87. SIGNATURE OF JURY                  [Illegible]</p>		<p>88. SIGNATURE OF JURY                  [Illegible]</p>	
<p>89. SIGNATURE OF JURY                  [Illegible]</p>		<p>90. SIGNATURE OF JURY                  [Illegible]</p>	
<p>91. SIGNATURE OF JURY                  [Illegible]</p>		<p>92. SIGNATURE OF JURY                  [Illegible]</p>	
<p>93. SIGNATURE OF JURY                  [Illegible]</p>		<p>94. SIGNATURE OF JURY                  [Illegible]</p>	
<p>95. SIGNATURE OF JURY                  [Illegible]</p>		<p>96. SIGNATURE OF JURY                  [Illegible]</p>	
<p>97. SIGNATURE OF JURY                  [Illegible]</p>		<p>98. SIGNATURE OF JURY                  [Illegible]</p>	
<p>99. SIGNATURE OF JURY                  [Illegible]</p>		<p>100. SIGNATURE OF JURY                  [Illegible]</p>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Wye Mills</b>				c. LENGTH OF STAY IN 1b <b>none</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Beverley Ann Conley</b>				4. DATE OF DEATH <b>July 14 19 59</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1942</b>	
9. AGE (In years last birthday) <b>16</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>school</b>		11. BIRTHPLACE (State or foreign country) <b>Church Hill, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.A.</b>							
13. FATHER'S NAME <b>Griffin Conley</b>				14. MOTHER'S MAIDEN NAME <b>Hattie M. Ervin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>Griffin Conley Church Hill, Md.</b>			
17. INFORMANT <b>Griffin Conley Church Hill, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe intracranial damage</b> <b>824x</b> DUE TO <b>crushing injury to base of skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Thrown from moving car on highway against post</b>			
20c. TIME OF INJURY Month, Day, Year <b>10-45 P. m. 7-14 19 59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>highway</b>		20f. (City or town) <b>nr. Wye Mills Q. A. Md.</b> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>C. R. Layton</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>C. R. Layton</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>7-15-59</b>			
22a. BURIAL, CREMATION, REMAINS SPECIALLY HANDLED <b>buried</b>		22b. DATE THEREOF <b>7-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill</b>		22d. LOCATION (City, town, or county) <b>Church Hill, Maryland</b> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulois Greensboro, Md.</b> ADDRESS _____				24a. REC'D BY REGISTRAR <b>JUL 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the Registrar for burial, cremation, or removal.



8341

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SUDLERSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BLACKISTON NURSING HOME</u>		1d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MABEL G GREEN</u>		4. DATE OF DEATH Month Day Year <u>JULY 24 1959</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 5-1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN FLEMING</u>		14. MOTHER'S MAIDEN NAME <u>ELLA FORAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR. FRANK GREEN</u>		Address <u>CHURCH HILL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2</u> , 19 <u>59</u> , to <u>July 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>59</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frederickville Md 21729</u> DATE SIGNED <u>7/29/59</u>			
ACTUAL SIGNATURE <u>C. H. METCALFE</u> M.D.		PHYSICIAN'S NAME (Type) <u>C. H. METCALFE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 27</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Q. 10. The following are the names of the various parts of the human body. Write the names of the parts of the body which are not visible to the eye.

26

3

7

Date Sent: 8/6/15 via [redacted]

1. *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue and red regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy in the form of ATP and NADPH.

1999

8342

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kings town</u>		c. LENGTH OF STAY IN TB <u>10</u> years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD out of Chestertown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hans</u> Middle <u>C.</u> Last <u>Hanson</u>		4. DATE OF DEATH Month <u>7/19/59</u> Day <u>19</u> Year <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1869</u>
9. AGE (In years lost birthday) yrs. <u>90</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Hanson</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT Address <u>Mrs. Warden F. Yost</u> <u>Chestertown, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.0</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>58</u> , to <u>19 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19 July</u> , 19 <u>59</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Harry Paul Ross</u> M.D. ADDRESS (Street, city or town, state) <u>203 N Queen St</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS</u>		<u>Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and completed. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and page 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08323

8343

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Annes</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Queen Annes</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>M.</u> Last <u>Jackson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Hartley, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Frances Ann Cahall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Maude R. Jackson,</u>		Address <u>Barclay, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage of neck, face &amp; throat</u> 191.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 2</u> , 1959, to <u>July 3</u> , 1959, that I last saw the deceased alive on <u>July 2</u> , 1959, and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>C. H. Metcalfe</u> M.D. <u>Sudlersville, Md.</u> 7/4/59 PHYSICIAN'S NAME (Type) <u>C. H. METCALFE</u> <u>SUDLERSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 6, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Templeville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Templeville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>	
ADDRESS <u>Wellington, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8344 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118324

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Queen Anne's</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Ann Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 02-50-2</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>339 Cedar Hill Lane</u>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Frank</u> Last <u>Leake</u>				<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>17</u> Year <u>1959</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Feb. 20, 1896</u>				
<b>9. AGE</b> (In years last birthday) <u>63</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u>		<b>IF UNDER 24 HRS.</b> Hours <u>—</u> Min. <u>—</u>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Steel</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>				
<b>13. FATHER'S NAME</b> <u>Not Known</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Not Known</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Robert J. Leake</u> Address <u>Box 248 Old Oak Rd. Severn, Md.</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>Myocardial Infarction</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>(b)</b>  <u>Coronary Occlusion</u>  <b>DUE TO (c)</b>  <u>—</u> </td> <td style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>Few Minutes</u> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <u>Coronary Occlusion</u> <b>DUE TO (c)</b> <u>—</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Few Minutes</u>
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <u>Coronary Occlusion</u> <b>DUE TO (c)</b> <u>—</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Few Minutes</u>						
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>None</u>								
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>						
<b>20c. TIME OF INJURY</b> Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>—</u>				
<b>20f. (City or town)</b> <u>—</u>		<b>(County)</b> <u>—</u>		<b>(State)</b> <u>—</u>				
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
<b>ACTUAL SIGNATURE</b> <u>Irwin S. Hoyt</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>7/17/59</u>				
<b>EXAMINER'S NAME (Type)</b> <u>Irwin G. Hoyt M.D.</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>July 20-1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>				
<b>22d. LOCATION (City, town, or county)</b> <u>Brooklyn RFD</u>		<b>(State)</b> <u>Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert P. Ware - Glen Burnie</u>				
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <u>JUL 21 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

100

8345

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Green Anne's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>O. A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>			c. LENGTH OF STAY IN 1b <u>18 yr.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nathaniel Clothier Leverage</u>			4. DATE OF DEATH Month Day Year <u>July 20 1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1875</u>		9. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Del.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Nathaniel Leverage</u>		
14. MOTHER'S MAIDEN NAME <u>Sally Crother</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>—</u>			INFORMANT Address <u>MRS. LEVERAGE = CENTREVILLE MD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hypertensive, Arteriosclerotic</u> (c) <u>Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>Sev. Yrs.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7/17/59</u>	
20f. (City or town) <u>Centreville</u>		(County) (State)			
21. I certify that I attended the deceased from <u>7/17</u> , 19 <u>59</u> , to <u>7/20</u> , 19 <u>59</u> , that I lost sown the deceased alive on <u>7/17</u> , 19 <u>59</u> , and that death occurred at <u>7/20</u> , 19 <u>59</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		DATE SIGNED <u>7/20/59</u>		ADDRESS (Street, city or town, state) <u>Centreville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 23</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>	
22d. LOCATION (City, town, or county) <u>Ind.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Ind.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Centralville 1876  
M. W. Jones  
Centralville  
July 20 1876

W. W. Jones  
Centralville  
July 20 1876  
U.S.A.  
Centralville  
July 20 1876

Centralville  
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Centralville  
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Centralville  
July 20 1876  
Centralville  
July 20 1876

8346

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pondtown, Rural Millington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pondtown, Rural Millington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>PINKNEY</b> Last <b>PINKNEY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 8, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Pinkney</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Alice Wright, Rural Millington, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Artery Sclerosis</b> DUE TO (c) <b>Chronic Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Stroke</b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stroke</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>2:10</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 3, 1959</b> , to <b>July 28, 1959</b> , that I last saw the deceased alive on <b>July 28, 1959</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>W. H. Whitehead, M.D. Rock Hill, Md. 7/30/59</b>			
ACTUAL SIGNATURE <b>W. H. Whitehead</b>		PHYSICIAN'S NAME (Type) <b>Dr. C. H. MOTEALE</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>August 1, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pondtown, Rural Millington, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Vellous</b>		24a. REC'D BY REGISTRAR <b>AUG 3 1959</b>	
ADDRESS <b>Millington Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kneass</b>	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  [Illegible]</p>		<p>AGE                  [Illegible]</p>		<p>SEX                  [Illegible]</p>		<p>RACE                  [Illegible]</p>	
<p>DATE OF DEATH                  [Illegible]</p>		<p>TIME OF DEATH                  [Illegible]</p>		<p>PLACE OF DEATH                  [Illegible]</p>		<p>CAUSE OF DEATH                  [Illegible]</p>	
<p>PLACE OF BIRTH                  [Illegible]</p>		<p>DATE OF BIRTH                  [Illegible]</p>		<p>PLACE OF DEATH                  [Illegible]</p>		<p>CAUSE OF DEATH                  [Illegible]</p>	
<p>NAME OF DECEASED                  [Illegible]</p>		<p>AGE                  [Illegible]</p>		<p>SEX                  [Illegible]</p>		<p>RACE                  [Illegible]</p>	
<p>DATE OF DEATH                  [Illegible]</p>		<p>TIME OF DEATH                  [Illegible]</p>		<p>PLACE OF DEATH                  [Illegible]</p>		<p>CAUSE OF DEATH                  [Illegible]</p>	
<p>PLACE OF BIRTH                  [Illegible]</p>		<p>DATE OF BIRTH                  [Illegible]</p>		<p>PLACE OF DEATH                  [Illegible]</p>		<p>CAUSE OF DEATH                  [Illegible]</p>	
<p>NAME OF DECEASED                  [Illegible]</p>		<p>AGE                  [Illegible]</p>		<p>SEX                  [Illegible]</p>		<p>RACE                  [Illegible]</p>	
<p>DATE OF DEATH                  [Illegible]</p>		<p>TIME OF DEATH                  [Illegible]</p>		<p>PLACE OF DEATH                  [Illegible]</p>		<p>CAUSE OF DEATH                  [Illegible]</p>	
<p>PLACE OF BIRTH                  [Illegible]</p>		<p>DATE OF BIRTH                  [Illegible]</p>		<p>PLACE OF DEATH                  [Illegible]</p>		<p>CAUSE OF DEATH                  [Illegible]</p>	

may be retained by the hospital. The attending physician and complete the certificate has been signed by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8347 Item 13 Film G244 7-20-59 et  
CERTIFICATE OF DEATH

08327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PERCY</u> First <u>A.</u> Middle <u>STALLINGS</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20-1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Stalling</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mrs. Percy Stallings</u> Address <u>Chester</u>	
17. INFORMANT <u>Mrs. Percy Stallings</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, congestive heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardio-vascular disease</u> (c) <u>Generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at</u>		20f. (City or town) (County) (State) <u>St</u>	
21. I certify that I attended the deceased from <u>May 10, 19 56</u> to <u>July 5, 19 59</u> , that I last saw the deceased alive on <u>July 5, 19 59</u> , and that death occurred at <u>12:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore Sattelmaier</u>		ADDRESS (Street, city or town, state) <u>Stevensville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Theodore Sattelmaier</u>		DATE SIGNED <u>July 5, 19 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 7</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u>		ADDRESS <u>Church Hill, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Edgar L. Kane</u>	

# CERTIFICATE OF DEATH

1951

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

MARRIAGE

DATE OF DEATH

TIME

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF DEATH

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